Appendix 20

Prior Authorization Request Form Physician Otological Report (PA/POR) Completion Instructions

The Prior Authorization Request Form Physician Otological Report (PA/POR) is required by Wisconsin Medicaid when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the recipient's medical record. Upon completion, give one copy to the recipient to take to the testing center and retain a second copy for your files. Providers may order carbon paper copies of the PA/POR by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

For more information about completing PA requests, providers may call Provider Services at (800) 947-9627 or (608) 221-9883.

Element 1 — Physician Name, Address (Street, City, State, ZIP Code)

Enter the name and address, including ZIP code, of the requesting physician.

Element 2 — Evaluation Date

Enter the date the recipient was examined in MM/DD/YYYY format.

Element 3 — Physician's Signature and Date

The requesting physician must sign the form and enter the date the request is made.

Element 4 — Physician's UPIN, Medicaid, or License Number

Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number, or license number of the physician.

Element 5 — Physician's Telephone Number

Enter the telephone number, including area code, of the requesting physician.

Element 6 — Recipient's Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 7 — Sex

Enter an 'X' in the appropriate box.

Element 8 — Recipient Address (Street, City, State, ZIP Code)

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 9 — Recipient's Name (Last, First, M.I.) as on Medicaid ID Card

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 10 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 11 — Medical History of Hearing Loss
Enter the recipient's medical history of hearing loss (if any).

Element 12 — Pertinent Otological Findings
Enter an 'X' in the appropriate box(es) and describe all problems.

Element 13 — Additional Findings
Describe any additional findings not covered in Element 11.

Element 14 — Clinical Diagnosis of Hearing Status
Enter the diagnosis of the recipient's hearing status.

Element 15 — Medical, Cognitive, or Developmental Problems
Describe any medical cognitive or developmental problems of the recipient.

Element 16 — Physician's Recommendations
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.